Quick Reference Guide

Formulary Information • For a detailed listing of covered drugs, excluded drugs and quantity limits	• www.tricare.osd.mil/pharmacy/tmop.cfm • Toll-free, 1.866.DOD.TMOP (1.866.363.8667)
Prescribing Restrictions • To find out whether your prescription requires prior authorization or has quantity limits	• www.tricare.osd.mil/pharmacy/tmop.cfm • Toll-free, 1.866.DOD.TMOP (1.866.363.8667)
Injectables and Over-the-Counter Drugs • In general, injectable and over-the-counter medications are available only if specifically listed as Covered Drugs. • Diabetic supplies — including test strips, syringes and needles — are covered products.	• www.tricare.osd.mil/pharmacy/tmop.cfm • Toll-free, 1.866.DOD.TMOP (1.866.363.8667)
Order a Refill	• www.express-scripts.com/TRICARE • Toll-free, 1.866.DOD.TMOP (1.866.363.8667)
Check on the Status of Your Order	• www.express-scripts.com/TRICARE • Toll-free, 1.866.DOD.TMOP (1.866.363.8667)
Get a Mail Order Registration Form	• www.express-scripts.com/TRICARE • Toll-free, 1.866.DOD.TMOP (1.866.363.8667)
Speak to a Registered Pharmacist	• Toll-free, 1.866.DOD.TMOP (1.866.363.8667)

Contact Us

Within the United States	• Toll-free, 1.866.DOD.TMOP (1.866.363.8667)
Outside the United States	• For on-base commercial: Toll-free, 1.866.ASK4PEC (1.866.275.4732); otherwise, check the PEC Web site for specific in-country, toll-free service where established
TDD If Your Hearing Is Impaired	• Toll-free, 1.877.540.6261
Online	• www.express-scripts.com/TRICARE
Mailing Address	• PO Box 52150 Phoenix, AZ 85072-9954

Department of Defense

TRICARE
Mail Order Pharmacy
Beneficiary Guide

For Eligible Uniformed Services Health System Beneficiaries

TRICARE

EXPRESS SCRIPTS®

How to Use Express Scripts

To Fill a New Prescription by Mail

- Ask your doctor to write a new prescription for the maximum days supply allowed (90-day supply on most medications).
- Complete the Mail Order Registration Form attached to this guide. This form needs to be completed only once, unless health conditions change.
- Insert the form, your written prescription, and mail your payment by credit card (preferred), check or money order in the pre-addressed, postage-paid envelope. To ensure proper prescription fulfillment, follow all instructions on the order form.

To Fill a New Prescription by Fax

- You can ask your doctor to fax your new prescription directly to Express Scripts, toll-free, 1.877.895.1900. Overseas, please fax to 1.602.586.3911.

Note: *Only prescriptions faxed directly from your doctor's office can be accepted. Prescriptions for Schedule II controlled substances cannot be faxed; by law, they must be mailed.*

To Order Refills Online for Delivery by Mail

- Go to: www.express-scripts.com/TRICARE.
- At your first online visit, complete the brief registration process. This will make future visits fast and easy. The Web site gives you access to information about your order status, refills, and general prescription drugs and health conditions.

To Order Refills by Phone for Delivery by Mail

- Call, toll-free, 1.866.DOD.TMOP (1.866.363.8667).
- Have your sponsor's Social Security number, your prescription number and credit card information ready when you call.

Time to Refill: *You can expect your order to arrive at U.S. postal addresses within 14 days. To make sure you receive your refills before your current supply runs out, re-order at least two weeks before you need your refill. You may want to allow a few extra days for APO/FPO delivery.*

Delivery Information: *Prescriptions can be mailed to any U.S. address, including temporary addresses, APO and FPO. If you are assigned to an embassy and do not have an APO/FPO address, you must use the embassy address. Prescriptions cannot be mailed to private foreign addresses.*

Note: *Refrigerated medications cannot be shipped to APO/FPO addresses.*

About Your Copayment

Your copayment is based on the type of medicine you and your doctor choose.

Copayment for up to 90-Day Supply

Type of Drug	Active Duty Personnel	All Other Beneficiaries
Generic	$0	$3
Formulary Brand-Name	$0	$9
Non-Formulary Brand-Name	Approval Required*	$22

**Active duty personel may obtain non-formulary drugs at a $0 copayment only if medical necessity has been established. Medical necessity information should be submitted along with the prescriptions. The DoD Pharmacy and Therapeutics Committee may set quantity limits on some medications. For more information, go to www.tricare.osd.mil/pharmacy/tmop.cfm.*

If You Have Other Health Insurance

If you are covered by other health insurance (OHI) with a pharmacy benefit, you may not use TMOP unless the other plan does not cover the medication needed or coverage from your other plan has been exhausted.

- If the medication needed is not covered by your OHI, submit the prescription and the Explanation of Benefits from the OHI to Express Scripts. If the drug is covered by TMOP, Express Scripts will fill the prescription.
- If you reach your OHI's benefit cap, submit a copy of the cap notice to Express Scripts with your prescription. If the drug is covered by TMOP, Express Scripts will fill the prescription until your OHI pharmacy benefit is renewed.

If Your Prescription Is Denied

Under certain circumstances, you may have the right to appeal decisions related to your benefits.

If your prescription is denied, please call 1.866.DOD.TMOP (1.866.363.8667) for instructions regarding your right to appeal.

INSTRUCTIONS FOR PLACING YOUR ORDER

Contact your doctor to write a new prescription for up to a three-month supply with authorized refills for up to one year.

OPTION 1: MAIL Your Order

1. Complete the New Patient Mail Order Form enclosed.
2. Attach your prescriptions to the order form.
3. Mail the New Patient Mail Order Form and your prescriptions to:

Express Scripts, Inc.
PO Box 52150
Phoenix, AZ 85072-9954

CLIENT ID:
TMOP / DOD

OPTION 2: FAX Your Order

1. Complete the New Patient Mail Order Form enclosed.
2. Ask your doctor to fax the New Patient Order Form and your written prescriptions to:

FAX: 1-877-895-1900 (OVERSEAS FAX: 1-602-586-3911)

Legally, we can only accept a faxed prescription from your DOCTOR'S OFFICE. Faxes sent from other locations (such as your home or workplace) will not be accepted.

DOCTOR NOTE: We cannot accept Schedule II controlled substances by fax. All prescriptions for these medications must be mailed.

3300

NEW PATIENT MAIL ORDER FORM

PLEASE PRINT IN **ALL CAPITAL LETTERS** USING **BLACK INK**.

IF THERE ARE MORE THAN 3 FAMILY MEMBERS, WRITE THE INFORMATION ON A SEPARATE PIECE OF PAPER.

1. PERSONAL INFORMATION

SPONSOR

ID NUMBER ___

FIRST NAME ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ M.I. ___

LAST NAME ___

DRUG ALLERGIES (CHECK ALL THAT APPLY) PENICILLIN (01) ___ ASPIRIN (03) ___ CODEINE (04) ___ SULFA (15) ___

TETRACYCLINE (07) ___ ERYTHROMYCIN (09) ___ OTHER: _____

NO KNOWN DRUG ALLERGIES (00) ___ BIRTH DATE ___ ___ – ___ ___ – ___ ___ (M M – D D – Y Y) GENDER ___

MAILING: YOU MUST PROVIDE A U.S. POSTAL ADDRESS. PRESCRIPTIONS CANNOT BE MAILED TO PRIVATE FOREIGN ADDRESSES.

(U.S. POSTAL ADDRESS, INCLUDING APO/FPO) ___

CITY ___

STATE ___ ___ ZIP CODE ___ ___ ___ ___ ___ – ___ ___ ___ ___

CLIENT ID: TMOP / DOD

PHONE # ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

PHYSICIAN LAST NAME ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

PHYSICIAN PHONE # ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

FAMILY MEMBER 1

FIRST NAME ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ M.I. ___

LAST NAME ___

DRUG ALLERGIES (CHECK ALL THAT APPLY) PENICILLIN (01) ___ ASPIRIN (03) ___ CODEINE (04) ___ SULFA (15) ___

TETRACYCLINE (07) ___ ERYTHROMYCIN (09) ___ OTHER: _____

NO KNOWN DRUG ALLERGIES (00) ___ BIRTH DATE ___ ___ – ___ ___ – ___ ___ (M M – D D – Y Y) GENDER ___

PHYSICIAN LAST NAME ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

PHYSICIAN PHONE # ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

FAMILY MEMBER 2

FIRST NAME ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ M.I. ___

LAST NAME ___

DRUG ALLERGIES (CHECK ALL THAT APPLY) PENICILLIN (01) ___ ASPIRIN (03) ___ CODEINE (04) ___ SULFA (15) ___

TETRACYCLINE (07) ___ ERYTHROMYCIN (09) ___ OTHER: _____

NO KNOWN DRUG ALLERGIES (00) ___ BIRTH DATE ___ ___ – ___ ___ – ___ ___ (M M – D D – Y Y) GENDER ___

PHYSICIAN LAST NAME ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

PHYSICIAN PHONE # ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

NEW PATIENT MAIL ORDER FORM

FAMILY MEMBER 3

FIRST NAME ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ M.I. ___

LAST NAME ___

DRUG ALLERGIES (CHECK ALL THAT APPLY) PENICILLIN (01) ___ ASPIRIN (03) ___ CODEINE (04) ___ SULFA (15) ___

TETRACYCLINE (07) ___ ERYTHROMYCIN (09) ___ OTHER: _____

NO KNOWN DRUG ALLERGIES (00) ___ BIRTH DATE ___ ___ – ___ ___ – ___ ___ GENDER ___
M M D D Y Y

PHYSICIAN LAST NAME ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

PHYSICIAN PHONE # ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

2. PAYMENT METHOD

STANDARD DELIVERY OF YOUR ORDER IS **FREE**. YOUR ORDER WILL ARRIVE WITHIN 14 DAYS FROM THE DATE WE RECEIVE YOUR ORDER. PLEASE INCLUDE PAYMENT WITH YOUR ORDER. **DO NOT SEND CASH**.

TO EXPEDITE SHIPPING, YOU MAY CHOOSE TO HAVE YOUR ORDER SENT BY NEXT-DAY DELIVERY, AFTER IT IS PROCESSED, FOR AN ADDITIONAL CHARGE OF $18. (NOTE: THIS WILL ONLY AFFECT SHIPPING TIME, NOT THE PROCESSING OF YOUR ORDER.)

NOTE: YOUR CREDIT CARD WILL BE CHARGED ACCORDANCE WITH YOUR PRESCRIPTION PLAN. ALL FUTURE ORDERS WILL BE CHARGED TO THIS CREDIT CARD, UNLESS PAYMENT (CHECK) ACCOMPANIES THE ORDER.

CLIENT ID: TMOP / DOD

CREDIT CARD # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

CARDHOLDER NAME _____ **EXPIRATION DATE** ___ ___ – ___ ___
PLEASE PRINT NAME AS IT APPEARS ON CREDIT CARD M M Y Y

_____
AUTHORIZED SIGNATURE

NOTE: IF PAYING BY CHECK OR MONEY ORDER, PLEASE REFER TO YOUR PRESCRIPTION PLAN MATERIALS FOR COPAY.

CHECK/MONEY ORDER ___ **AMOUNT ENCLOSED $** ___ ___ ___ ___ . ___ ___

3. SIGNATURE REQUIRED

PLEASE CHECK ANY OF THE TWO OPTIONS (IF APPLICABLE) AND SIGN THE FOLLOWING STATEMENT.

___ I WOULD LIKE MY PRESCRIPTIONS DISPENSED WITH NON-CHILD RESISTANT (EASY OPEN) CAPS.

___ I REQUEST THAT THIS AND FUTURE ORDERS BE SHIPPED "SIGNATURE REQUIRED" FOR AN ADDITIONAL CHARGE.

I CERTIFY THAT ALL THE INFORMATION ON THIS FORM IS CORRECT, INCLUDING ANY SELECTIONS MADE FOR SENDING MY ORDER SIGNATURE REQUIRED OR WITH NON-CHILD RESISTANT (EASY OPEN) CAPS. I PERMIT EXPRESS SCRIPTS INC. TO RELEASE ALL INFORMATION ON THIS FORM CONCERNING PRESCRIPTION ORDERS TO MY PLAN SPONSOR, ADMINISTRATOR OR HEALTH PLAN FOR THE PURPOSE OF PAYMENT, TREATMENT, OR HEALTH CARE OPERATIONS. _____
AUTHORIZED SIGNATURE

4. REVIEW YOUR PRESCRIPTION

AS REQUIRED BY THE U.S. DEPARTMENT OF DEFENSE, WE WILL DISPENSE FDA APPROVED GENERIC MEDICATIONS UNLESS YOUR PHYSICIAN ESTABLISHES THAT THE BRAND-NAME MEDICATION IS MEDICALLY NECESSARY.

- **PLEASE HAVE YOUR PHYSICIAN PRESCRIBE UP TO THE MAXIMUM DAYS SUPPLY ALLOWED.** (A 90-DAY SUPPLY FOR MOST MEDICATIONS)
- **CHECK TO SEE IF THE PATIENT NAME, ADDRESS AND DATE OF BIRTH IS CLEARLY WRITTEN ON THE PRESCRIPTION.** IF NOT, PRINT THE PATIENT'S FULL NAME, ADDRESS, PHONE NUMBER AND DATE OF BIRTH ON THE BACK OF THE PRESCRIPTION.
- **CHECK TO SEE IF THE PHYSICIAN SIGNATURE IS LEGIBLE AND PHYSICIAN PHONE NUMBER IS PRINTED ON THE PRESCRIPTION.** IF NOT, PLEASE CIRCLE THE PHYSICIAN'S NAME ON THE PRESCRIPTION, OR PRINT THE PHYSICIAN NAME AND PHONE NUMBER, INCLUDING AREA CODE ON THE BACK OF THE PRESCRIPTION.

HEARING IMPAIRED: 1.877.540.6261 TOLL-FREE: 1.866.DOD.TMOP (1.866.363.8667)
FOR REFILLS: www.express-scripts.com

TRICARE MAIL ORDER PHARMACY PROGRAM
19 June 2006

DOD Pharmacy Operations Center	800-785-348 Toll-free from Italy

EXPRESS SCRIPTS

Doctor Call-in (new prescription)	1-877-283-3858 or 602-225-0005 X 436914
Doctor Fax-in (new prescription)	1-877-895-1900
Patient Customer Assistance	1-866-363-8667 Not Toll-free from Italy